

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037255

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 106

FILED OCT 8 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>Maryland Heights</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>502 Fee Fee Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Winfred</u> Middle <u>Kenney</u> Last <u>Foster</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1963</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alton Brick Co.</u>	9. AGE (last birthday) <u>50</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR.
11a. FATHER'S NAME <u>Elmer Foster</u>		11b. BIRTHPLACE (City and state or country) <u>Camp, Ark.</u>	
12a. MOTHER'S MAIDEN NAME <u>Fern Young</u>		12b. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		14. NAME OF HUSBAND OR WIFE <u>Anna (Annie) Foster</u>	
15. SOCIAL SECURITY NO. <u>[redacted]</u>		16. INFORMANT <u>Anna (Annie C.) Foster-502 Fee Fee Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>8-15-61</u> to <u>10-1-63</u> and last saw <u>her</u> alive on <u>8-7-63</u> Death occurred at <u>10-1-63 71 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. St. Conrad M.D.</u> (Degree or title)		22b. ADDRESS <u>114 N. Main, St. Charles Mo</u>	
22c. DATE SIGNED <u>10-2-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-4-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Wellston, Mo.</u>
24. FUNERAL DIRECTOR <u>Baumann Bros. Funeral Home</u> <u>2504 Woodson Rd., Overland 14, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 2, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Salma Stewart</u>			

USE BLACK INK

OR

TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.